

**TEEN PREGNANCY PREVENTION INITIATIVE RFP  
INTENT TO APPLY FORM**

\_\_\_\_\_  
Agency

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Fax

\_\_\_\_\_  
Contact Person

\_\_\_\_\_  
Title

\_\_\_\_\_  
Email

**Type of Agency:** (check one, only)

Not-for-profit 501(c)(3) \_\_\_\_\_

Tribal Council \_\_\_\_\_

Health Department \_\_\_\_\_

Hospital or Healthcare Org. \_\_\_\_\_

Federally Qualified Health Center \_\_\_\_\_

Public/Private College or University \_\_\_\_\_

School or LHD \_\_\_\_\_

Faith-Based Organization \_\_\_\_\_

The following information is requested to assist in matching reviewers to applications. MDCH understands that it is preliminary and is **non-binding**.

1. **Service area** - please identify the primary communities to be served by your program.

\_\_\_\_\_

2. **Proposed target population** – Identify by age and setting

\_\_\_\_\_

3. **Primary evidence-based intervention model to be implemented**

\_\_\_\_\_

4. **Estimated 12-month funding request:** \$ \_\_\_\_\_

\_\_\_\_\_  
Signature of Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please Print Name and Title

Please fax or email to:

**Kara Anderson**  
**Teen Pregnancy Prevention Consultant**  
**Michigan Department of Community Health**  
[AndersonK10@michigan.gov](mailto:AndersonK10@michigan.gov)  
(517) 335-8294 (fax)